

tions of epinephrin, and the itching by phenol washes. The physician should look carefully for the appearance of complications of pneumonia, and not carelessly ascribe fever, etc., to "serum sickness." Hospitals and certain health boards are prepared to determine the type of pneumococcus in any case, and the serum is now being produced by some of the big commercial houses, so that the serum treatment in Type I cases should be used widely, the danger from any untoward results from the serum being negligible when compared to the benefit to be derived from its use.

Visceral Disturbances in Patients with Cutaneous Lesions of the Erythema Group.—CHRISTIAN (*Jour. Am. Med. Assn.*, 1917, **Ixix**, No. 5, p. 325) discusses the group of cases exhibiting various symptoms on the part of the viscera, but showing in common skin lesions of the erythema group. Diagnostic mistakes are often made; abdominal symptoms may lead to needless laparotomies, and hematuria may suggest surgical conditions of the kidney or nephritis. Renal changes similar to those in the skin may simulate nephritis, even to the stage of uremia, or there may exist a severe nephritis, to which the skin lesions are secondary. The skin lesions, needless to say, are exceedingly variable in character, as the variety of names applied to them by dermatologists proves. The synthesis of large numbers of these cases with skin and visceral manifestations into one group, in which various combinations of erythema, hemorrhage, edema, and exudation occur in the skin surfaces and in the viscera, seems more logical than to separate the cases into countless groups depending upon the location of the lesion and its exact features. This was discussed years ago by Osler, and as time has passed and serums have been widely used, it has been found that many cases of so-called serum sickness bear close resemblance to the cases in the erythema class, probably further justifying the grouping of all of these cases, though our knowledge of definite etiology in the erythema group is still very slight. The author reports 10 cases, the symptoms being grouped as follows: Case 1, urticaria, albuminuria, hyperpermeability of the kidney. Case 2, purpura, abdominal pain, blood in the stools. Case 3, purpura, abdominal pain, pain and swelling of the ankles, hematuria. Case 4, purpura, diarrhea, blood in the stools, abdominal pain, painful, swollen joints. Case 5, purpura, painful joints, hematuria. Case 6, erythema nodosum, abdominal pain, vomiting, slight diarrhea. Case 7, erythema multiforme bullosum, gastric disturbance. Case 8, erythema multiforme vesiculosum, abdominal pain. Case 9, urticaria, intestinal obstruction. Case 10, purpura, arthritis, abdominal pain, hematuria, blood in stools. The study of these cases seems to convince the author that the symptoms are best explained by regarding the disease as due to disturbance in the small bloodvessels (vessels of the capillary, precapillary, and postcapillary group), focial in distribution, which causes dilatation, diapedesis, and exudation either singly or in combination. The ultimate cause is unknown, and the fact that these disturbances occur anywhere within the circulatory system will undeniably result in a large variety of symptoms. That this is so is proved by the extreme variability of the symptoms in any given case. The intestinal colic is the result of changes in the intestinal wall producing spasm, while the diarrhea and blood in the stools probably

result from serous exudation or hemorrhage into the wall of the bowel. The exact relation of the renal changes is not clear. Hematuria can occur from localized changes in the renal vessels, as in the intestine, and this was found to be true in case 10, when the kidneys at autopsy were found to contain numerous focal hemorrhages without a nephritis. In some of the cases study showed a markedly reduced renal function, and in others the question was raised whether or not the renal manifestations were not due to the same changes occurring in the kidney, which occurred in the skin or other tissues. This question is difficult to solve at the present time. It is also possible that the so-called "uremia" occurring occasionally in these cases is due to similar vascular changes in the brain, and is not secondary to the renal lesion. Christian concludes that there is a definite clinical entity, in which skin lesions of the erythema type occur in combination with visceral lesions of the same character. The visceral lesions may occur unaccompanied by skin manifestations, and as the symptomatology within the group is very complex, diagnosis of the visceral lesions may be very difficult in the absence of skin lesions at a given time.

SURGERY

UNDER THE CHARGE OF

T. TURNER THOMAS, M.D.,

ASSOCIATE PROFESSOR OF APPLIED ANATOMY AND ASSOCIATE IN SURGERY IN THE
UNIVERSITY OF PENNSYLVANIA; SURGEON TO THE PHILADELPHIA GENERAL
HOSPITAL AND ASSISTANT SURGEON TO THE UNIVERSITY HOSPITAL.

Arterioplasty after Arteriosecretion.—HOFFMANN (*Zentralbl. f. Chir.*, 1916, xliii, 981) says that if after the resection of an aneurysm, a free bleeding occurs from the peripheral cut end of the main arterial trunk, one may depend upon the sufficiency of the collateral circulation after ligation of both stumps. In other, older patients, the collateral circulation is not sufficiently good to rely upon such a procedure, lest the nutrition of the limb below should not be maintained. But there is a certain amount of collateral circulation in every case of aneurysm and one might give sufficient aid to it by conserving a portion of the main arterial current. Hoffmann proceeded as follows in a case of popliteal aneurysm: After extirpation of the aneurysmal sac which extended downward almost to the bifurcation of the popliteal artery and upward almost the length of this artery; a union of the central with the peripheral cut ends was impossible. The posterior tibial artery was divided just above where it gives off the peroneal artery. The peripheral cut ends here was ligated and the open central end turned upward for circular union with the central cut end of the popliteal artery. The peripheral stump of the popliteal was ligated close to its bifurcation into the anterior and posterior tibial arteries. The lumen of the turned up upper portion of the posterior tibial is seen to be continuous with that of the anterior tibial, and when after dividing obliquely